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Audit

Audit of Compliance with Physical Examination Proforma

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Abstract

Aims: To examine the compliance with local psychiatric admission guidelines requiring a Physical Examination Proforma to be completed for all psychiatric admissions as per Louth/Meath Mental Health Services Admission Policy, 2016 and, if necessary, introduce change in order to improve compliance with these local guidelines.

Background: The Royal College of Psychiatrists and NICE Guidelines both stress the importance of carrying out physical examination on psychiatric in-patients due to their high level of physical health issues. Carrying out and carefully documenting these physical examinations at the time of admissions allows physical health issues to be appropriately taken into account when creating management and medication plans and, in more severe cases, can allow diversion for medical treatment if that is required or the underlying cause of the presentation.

Methods: A review of the notes of all in-patients on a specific day in Unit 1, St Brigid's Complex, Ardee was carried out. Results were analysed and feedback obtained from non-consultant hospital doctors. The findings were presented during local teaching to both the consultant and NCHD bodies and means of improving compliance were discussed openly. These discussions led to a redesign of the proforma to make it shorter and simpler to complete. A re-audit was carried out during a single day on all in-patients in Unit 1 several months after the first phase of the audit. In-patients who remained in Unit 1 since the initial phase of the audit were excluded from the re-audit.

Results: The rate of proforma usage increased from 50% (10/20) to 100% (20/20). Furthermore in phase 1 the proformas were only partially completed with elements of the physical exam documented on the proforma, other components documented elsewhere in the admission notes and many elements omitted altogether. Only 15% (3/10) of the proformas contained a complete, documented physical examination. In the re-audit 80% (16/20) of the proformas were completed.

Conclusions: While all involved agreed that carrying out physical examination on all admissions was advisable the length and complexity of the initial proforma contributed to poor completion rates by NCHDs. A combination of teaching to underline its importance and a redesign focused on usability and speed led to significantly increased completion of the proforma with attendant benefits for patient assessment and treatment.

Keywords: Physical Health, Physical Examination, Medical Co Morbidities

Abbreviations: NICE - The National Institute for Health and Care Excellence NCHD - Non Consultant Hospital Doctor

Introduction

The Royal College of Psychiatrists and NICE Guidelines both stress the importance of carrying out physical examination on psychiatric in-patients due to their high level of physical health issues. Carrying out and carefully documenting these physical examinations at the time of admission allows physical health issues to be appropriately taken into account when creating management and medication plans and, in more severe cases, to allow diversion for medical treatment if that is required or the underlying cause of the presentation.

Monitoring physical health of patients in psychiatric settings is vital and is recommended by NICE in its guidelines; documentation of physical health assessment carried out at the right place is also imperative. According to Louth/Meath Mental Health Services Admission Policy, 2016, all psychiatric patients admitted should have their Physical Examination completed and recorded on Physical Examination Proforma.

Psychotropic medications can effect on physical health of psychiatric patients[1]. Patients with medical co-morbidities are more at risk from psychotropic medications compare to normal healthy population[2]. In addition, depression is considered as an independent risk factor for cardiac events in patients with coronary artery disease[3]. Adding that, depression may also possibly increase the risk of cardiovascular disease in population without medical co-morbidities. Hence, psychotropic medications are carefully chosen for treatment of individual patients to avoid any adverse events[1]. Depression is not the only risk factor for medical co-morbidities; other psychiatric problems also make patients vulnerable for physical health issues[1]. Moreover, prevalence of medical problems is relatively high in psychiatric patients compared to cohorts without mental health disorders[4]. The risk of medical co-morbidities do not always increase after prescribing psychotropic medications; the risk of cardiovascular disease also increases for patients suffering from anxiety and not necessarily using medications[5].

Psychiatric patients receiving psychotropic medications should have their physical health monitored regularly as recommended by NICE[6].

Methods

The audit cycle was completed in St Brigid's Complex, Ardee. The audit cycle comprised initial audit (phase 1), implementing changes following recommendations and re-audit to compare results with initial audit. All patients in Unit 1, which is an acute admission ward, were included for the audit and re-audit. Patients admitted in another ward, which is a long stay ward, were excluded in the audit cycle. The rationale for not including patients admitted in long stay ward was that these cohorts of patients are already well established on psychotropic medications and their physical health is regularly monitored. Data collection was carried out from physical health proforma completed upon admission and filed in notes. No patient identifiable data was collected during the audit cycle.

During phase1, a review of the notes of all in-patients on a specific day in Unit 1, St Brigid's Complex, Ardee was carried out. Data was collected from physical health proforma of each patient. This data was then entered in Xl-spread sheet for the analysis purpose. Results were analysed and feedback obtained from non-consultant hospital doctors. The findings were presented during local teaching to both the consultant and NCHD bodies and means of improving compliance were discussed openly. These discussions led to a redesign of the proforma to make it shorter and simpler to complete. This proforma was then attached to an assessment booklet, whereas physical health proforma was not part of an assessment booklet. A re-audit was carried out during a single day on all in-patients in Unit 1 several months after the first phase of the audit. In-patients who remained in Unit 1 since the initial phase of the audit were excluded from the re-audit.

Results

The results of initial audit demonstrated only 50% (10/20) compliance with physical health proforma. Furthermore, in phase 1 the proformas were only partially completed with elements of the physical exam documented on the proforma. In addition, other components were documented elsewhere in the admission notes and many elements omitted altogether. Only 15% (3/20) of the proformas contained a complete, documented physical examination.

One of the sections on proforma that lacked information significantly was information about patient's current circumstances. On the other hand, demographic details were recorded for only 50% of patients. However, admitting doctor's details were recorded on 35% (7/20) of proformas, the details of professional carrying out physical information was also not available on large number (19/20) of proformas.

Table 1:

	Yes	No	Partial
Patient Demographics	10	10	0
Date & Time of Admission	6	11	3
Referral Agency	7	13	0
Admission Status	8	12	0
Drug Allergies	6	14	0
GP Details	7	13	0
NOK Details	3	17	0
Religion	1	19	0
Marital Status	2	18	0
No of Children	2	18	0
Occupation	2	18	0
Nationality	3	17	0
No of Previous Admissions	1	19	0
Medical Card No	0	20	0
V.H.I	0	20	0
Provisional Diagnosis	6	14	0
Admitting Doctor Name	7	13	0
Admitting Doctor Signature	7	13	0
General Examination	9	11	0
CVS	9	11	0
R.S	9	11	0
C.N.S	9	11	0
Alimentary System	6	14	0
G.U.S	3	17	0
L.M.P	1	19	0
Signature	1	19	0
Date	8	12	0

Data analysis of the re-audit shows that 80% (16/20) of the proformas were been completed. In overall, there was a huge improvement seen in the results of the re- audit and doctor's details performing physical health was recorded on 75% of the proformas. Adding that, general examination section of the proforma demonstrated huge compliance of 80% along with Cardiovascular and Respiratory system.

Table 2:

	Yes	% Yes	No	% No
Name	12	60%	8	40%
DOB	10	50%	10	50%
General Examination	16	80%	4	20%
CVS	15	75%	5	25%
R.S	15	75%	5	25%
C.N.S	14	70%	6	30%
Alimentary System	14	70%	6	30%
G.U.S	14	70%	6	30%
L.M.P	6	30%	14	70%
Signature	15	75%	5	25%
Date	15	75%	5	25%

Discussion

A total of 20 patients in each phase of the audit were included for data analysis. The number of patients included may seem small for a research study with a different design; however, quantitative number is not taken into account with this particular design used. On the other hand, number of patients admitted in any acute ward is similar.

During data collected, it was apparent that physical examination findings were recorded in the notes instead and proforma was not used for some of patients, which is evident through results. Even though physical examination may have

been carried out, it was not possible to include in data analysis and results due to the study design.

The results of first phase demonstrated poor compliance with physical health proforma despite carrying out physical examinations and findings been recorded elsewhere in admission notes. It is an arguable fact that regardless of physical health proforma been filled, physical examination of patients are been carried out as per local and NICE guidelines. However, physical examinations documented elsewhere in the admission notes makes it difficult to locate; hence, a proforma is completed upon admission as a pre agreed standard procedure.

Once the results of initial audit were analysed, these results were presented in the local academic session to all the NCHDs and Consultant Psychiatrists. While all involved agreed the importance of carrying out physical examination on all patients upon admission; the design and complex nature of the initial proforma made very difficult for NCHDs to complete it. Adding that, some of the information, such as demographic details and personal information, was also repeated making it duplicate that had been recorded elsewhere in the notes. The physical health proforma was then redesigned and simplified to complete. Unnecessary and duplicate information was omitted in the new proforma and was attached with the initial psychiatric assessment booklet. The new physical health proforma was then implemented in the service after discussions with fellow NCHDs, Consultants and management.

Second phase of the audit cycle was conducted after number of months and redesigned physical health proforma been in circulation for some time. Data was again collected as per study design and methods and entered for analysis. These results demonstrated a huge improvement in compliance with physical health proforma after the change of practice. Although compliance with proforma has improved significantly, some gaps were noted to reach the desired outcome of 100% in practice. Case notes were studied to understand the reasons for not completing physical health proformas. Several themes emerged through case note reviews and one of the reasons was assumed that patient was transferred from medical ward of General Hospital after been medically cleared. Time and mode of admission also resulted in physical health proforma not been completed.

Conclusion

While all involved agreed that carrying out physical examination on all admissions was advisable; the length and complexity of the initial proforma contributed to poor completion rates by NCHDs. A combination of teaching to underline its importance and a redesign focused on usability and speed led to significantly increased completion of the proforma with attendant benefits for patient assessment and treatment.

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Competing Interests
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